# APPLICATION FOR INDIANA CONTROLLED SUBSTANCES REGISTRATION FOR NON-PRACTITIONERS

State Form 52616 (4-06)
Approved by State Board of Accounts, 2006

**INDIANA BOARD OF PHARMACY**
**PROFESSIONAL LICENSING AGENCY**
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2067
E-mail: pla4@pla.IN.gov

*INSTRUCTIONS: Please type or print all information.*

| FOR OFFICE USE ONLY | | |
|---|---|---|
| Application fee | Date fee paid (*month, day, year*) | Receipt number |
| Date of approval (*month, day, year*) | Registration number | Date of issuance (*month, day, year*) |

**DO NOT WRITE ABOVE THIS LINE**

**SECTION I**
***All applicants must complete this section. Practitioners should use State Form 34617.***

Please check one box

☐ Pharmacy ☐ Manufacturer ☐ Wholesale Distributor
☐ Analytical Laboratory ☐ Surgery Center ☐ Limited Permit
☐ Hospital / Clinic ☐ Teaching Institution ☐ Other _____

Name of facility

DBA (*if applicable*)

Name of pharmacy manager or person responsible for controlled substances (*attach curriculum vitae*)

Physical address of controlled premises (*number and street, city, state, and ZIP code*)

| Name of contact person | Title |
|---|---|
| Telephone number ( ) | E-mail address |

Drug schedules (*check all that apply*)

☐ 1 ☐ 2 ☐ 2 Narcotic ☐ 3 ☐ 3 Narcotic ☐ 4 ☐ 5

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include violation, location, date and disposition. Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a registration issued pursuant to this application.

1. Has the applicant, any of the agents or listed pharmacist ever been convicted of, pled guilty or nolo contendre to a violation of any federal, state or local law relating to the use, manufacturing, distribution or dispensing of controlled substances? ☐ Yes ☐ No
2. Has the applicant, any of the agents or listed pharmacist ever been convicted of, pled guilty or nolo contendre to any offense, misdemeanor or felony in any state? (*Except for minor violations of traffic laws resulting in fines*) ☐ Yes ☐ No
3. Have you ever had any action, discipline or revocation on a DEA (US Drug Enforcement Administration) registration or entered into a Memorandum of Understanding (MOU) on said registration? ☐ Yes ☐ No
4. Has the applicant, any of the agents, or the listed pharmacist been treated for drug or alcohol abuse? ☐ Yes ☐ No

## SECTION II
***All applicants, with the exception of pharmacies, must complete this section.***

List procedures to be performed that directly involve controlled substances (*attach additional sheet, if needed*). *Limited permit applicants do not need to list procedures.*

**TYPES & QUANTITIES OF DRUGS TO BE STORED (*attach additional sheet, if needed*)**

| NAME OF SUBSTANCE | SCHEDULE NUMBER | FORM / CONCENTRATION | QUANTITY |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**PRIMARY STORAGE OF CONTROLLED SUBSTANCES**

| TYPE OF CONTAINER | HOW SECURED | PERSON(S) WITH ACCESS |
|---|---|---|
| | | |
| | | |
| | | |

**SECONDARY STORAGE (*location of primary*)**

| TYPE (*ROOM, CAGE, ETC.*) | HOW SECURED | PERSON(S) WITH ACCESS |
|---|---|---|
| | | |
| | | |
| | | |

Who documents use / inventory?

How? (*Describe procedure for documentation.*)

## SECTION III - ADDITIONAL INFORMATION REQUIRED FOR CERTAIN NON-PRACTITIONERS

Surgery Centers:
- Names, credentials, past training, and copies of current DEA registrations of all medical staff;
- A copy of the agreement for pharmacy services, if applicable;
- Application is required to be signed by the medical director.

Humane Societies / Animal Control Facilities:
- Written documentation of the training of the personnel administering the drugs; and
- The name and license number of the veterinarian associated with the facility.

Researchers:
- A *one-page* summary of research objectives and research protocol; and
- Provide doses and dosing schedules for controlled substances.

Manufacturers:
- Describe products and manufacturing procedures.

Limited Permit:
- Type of facility;
- Documentation describing the ownership of the facility;
- Written documentation of the training of the personnel administering the drugs; and
- Verification that a licensed Indiana veterinarian holding a valid Indiana controlled substances registration and federal DEA registration has been retained to provide technical advice to the facility.

## SECTION IV - APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties of perjury that the statements made in this application are true, complete and correct.

| Signature of applicant | Date (*month, day, year*) |
|---|---|
| | |

| Printed name of applicant | Title |
|---|---|
| | |

## AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request, and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency or the Indiana Board of Pharmacy any files, documents, records or other information pertaining to the undersigned requested by the Agency or Board, or any of its authorized representatives in connection with processing my application for licensure as a pharmacist.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency and the Indiana Board of Pharmacy to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency and Committee from any and all liability in connection with such disclosure.

A photostatic copy of this authorization has the same force and effect as the original.

## AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to the same.

| Signature of applicant | Date signed (*month, day, year*) |
|---|---|
| | |